

Rite Share Co-Pay Only

Adding Members to an Existing Group Enrollment Form

Please note that completing this form is not necessary if you currently have a Rhode Island Medical Assistance number.

Group Name			
Group Number			
Group Tax ID Number			
Office Address	Street	Suite/Room	
	City	State	ZIP
	Contact Name	Title	Phone

Mail To: Address	Street	Suite/Room	
	City	State	ZIP
	Contact Name	Title	Phone

Group Member's Information*	Last Name	First Name	Middle Initial	Title
Group Member's Signature:	<div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="display: flex; justify-content: space-between; font-size: small;"> Sign Date </div>			
Group Member's Information*	Last Name	First Name	Middle Initial	Title
Group Member's Signature:	<div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="display: flex; justify-content: space-between; font-size: small;"> Sign Date </div>			

Please enclose a copy of each member's license and NPI letter from CMS